

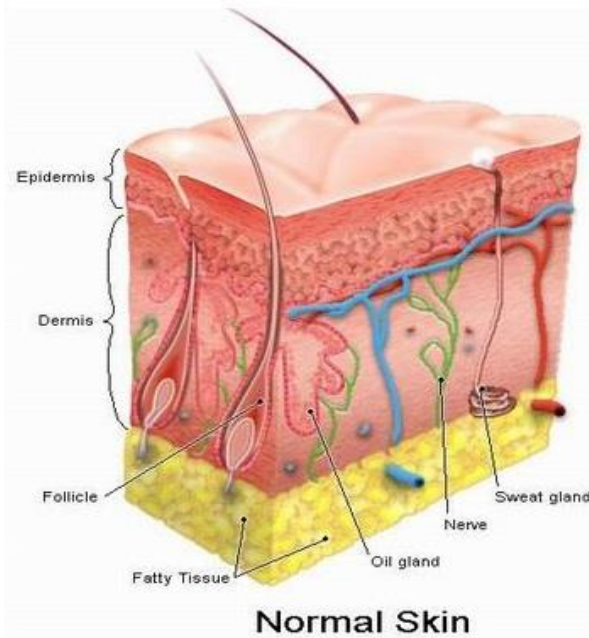
One Vision....One mission

ALL TEAM

PRESENT

Dermatology Revision

6th year



www.ALLTALABA.com

VISIT...

LANZAROTE
Caliente.COM

Bacterial infections

	Impetigo contagiosa	Folliculitis	Sycosis barbae	Furuncle	Carbuncle	Erythrasma	Cellulitis	erythrasma
Etiology	Cocci + poor hygiene & moisture or scabies & pediculosis	Staph aureus (infection of upper part of hair follicle)	Staph aureus (folliculitis of the beard area)	Infection of lower part of the hair follicle	Diabetes	Inflammation of upper dermis (B hemolytic strept)	INF of lower dermis (staph aureus – strept pyogenes)	Corynebacterium minutissimum (DM)
C/P	1- Ordinary 2- Bullous : new born – staph infection – may be fatal 3- Circinate : extension of ordinary 4- Ulcerative : crust & scars	Follicular pustules	Follicular pustules & papules	Red papules	Multiple deep boils open on surface by fistulae	Erythematous tender swollen area with sharp border + constitutional S	As erythrasma but illdefined border	Reddish brown patches in intertriginous areas / Give red fluorescence with wood's light
Complications	Post streptococcal glomerulonephritis					Lymphedema		
Treatment	Topical antiseptics + topical antibiotics and systemic if severe	Same	Same	Same	Incision & drainage + systemic AB	Erythromycin	Aggressive AB	Topical AB and antifungal ? systemic AB

Viral infections

	Herpes simplex	Herpes zoster	Warts	Molluscum contagiosum
Aetiology	HSV I : herpes labialis HSV II : herpes genitalis	Varicella Zoster virus	Human papilloma virus	Pox virus
C/P	1- HSV I : a. <u>superficial vesicles</u> perioroficial → ulcers → swollen gums & lymphadenopathy + constitutional manifestations b. <u>recurrent</u> attacks in lips & face less severe c. <u>ocular</u> type d. <u>herpetic whitlow</u> : in fingers very painful 2- HSV II : vesicles on genitals and ulcers / if pregnant → CS	Vesicles along distribution of a sensory nerve + local LNs enlargement – leave scar – give permanent immunity DANGEROUS in : Bilateral Old age Gangrenous Recurrent	1- Common warts : verruca papules 2- Plane warts : flat topped papules 3- Filiform warts : pedunculated 4- Digitiform warts : finger like 5- Planter warts : foot = tender – grow inward 6- Genital warts : moist foul smelling in MM & skin	Dome shaped papule with central umbilication and white cheesy material if squeezed – can be sexual
Complications	2ry infections / eye complications / CNS : <u>encephalitis</u> / <u>erythema</u> multiforme / <u>cancer cervix</u>	Eye complication ? <u>post herpetic</u> <u>neuralgia</u>	Oncogenicity (cervical cancer)	
Treatment	• Antiseptic lotions • Acyclovir cream 5 times daily 5 days • IDU for eye lesions • <u>Acyclovir tab 200 mg 5 X 5</u>	1- Topical : drying AS lotion / Acyclovir cream 2- Systemic : Acyclovir 800 mg 5 X 7 - Analgesics	1- Cautery : electro- cryo – laser – chemical 2- Podophyllon resin in alcohol : for venereal 3- Radiotherapy 4- Autosuggestion	Cauterization

Fungal infections

	Dermatophytes				Yeasts	
	Tinea capitis	Tinea circinata	Tinea pedis	Other types	Pityriasis versicolor	Candidiasis
Cause	Trichophyta & microspore	Trichophyta & microspore	Trichophyta & epidermophyta	1- <u>Tinea cruris</u> : scrotum not involed 2- <u>Tinea axillaris</u> 3- <u>Tinea barbae</u> 4- <u>Tinea mannum</u> : in palm 5- <u>Tinea uguium</u> : onychomycosis → thickened greenish nails	<u>Malassezia</u> furfur the pathogenic form of pityrosporum orbiculare	Candida albicans
C/P	1- <u>Scaly type</u> :child – bal patch with scales 2- <u>Black dot</u> : hair breaks leave dots 3- <u>Kerion</u> : also adult with boggy swelling & pustules → cicatricial alopecia 4- <u>Favus</u> : diffuse loss of hair with mousy odour yellow crusts → cicatricail alopecia	Annular patches with active <u>edge</u> and healing <u>centre</u> – <u>itching</u> is common on exposed surfaces	Sodden white macerated skin with bad dour between toes		<u>Macule</u> hypo or hyper pigmented with fine <u>scales</u> in upper chest arms – In <u>summer</u>	1- Cutaneous candidiasis : a. Intertrigo : i. Axilla & groin ii. Eriosio interdigitalis mastocytica iii. Angular chelitis iv. Napkin dermatitis b. Paronychia : nail fold tender – nail corrugated 2- Mucosalcandidiasis : oral thrush – vulvo vaginitis - balanitis
Diagnosis	1- <u>Wood's</u> : <u>green</u> 2- LM 3- <u>Culture</u> on saburoud	DD : herald patch			Wood's light gives <u>yellow</u> <u>Parker ink stain</u> : spagitti & meatballs appearance	
Treatment	<u>Topical</u> alone is useless (ketoconazole shampoo + <u>griseofulvin</u> tab for 2 months	Topical antifungal 2 daily + systemic griseofulvin for <u>3 W</u>	1- <u>Tincture</u> iodine 1 % 2- <u>Systemic</u> antifunal in sever cases		1- <u>Systemic</u> : ketoconazole 200X10 2- <u>Topical</u> : Na hyposulphide – imidazole – zinc pyrithione – white field – tincture iodine	1- <u>Topical</u> : castellani paint – nystatin oint 2- <u>Systemic</u> : mycostatin oral drops – Azoles – amphotericin B in sever

Scaly erythematous lesions

	Psoriasis	Lichen planus	Discoid Lupus erythematosus	Pityriasis rosea
Etiology	<u>Lack</u> of UV rays - Hemolytic infection - Hypocalcemia - Pregnancy - Trauma / psychogenic	- Psychological - Liver disease - <u>Sunrays</u> - Antimalarial – gold	Chronic scaly erythematous eruption in skin	Considered exanthematous reaction for upper respiratory <u>viral</u> infection (HHV 6-7)
C/P	Erythematous papule with shiny scales – <u>loosely</u> adherent – bleed on removal (<u>Auspitz</u>)	<u>Flat topped</u> polyangular violaceous itchy papules with <u>adherent</u> scales in flexor areas with severe <u>pruritis</u>	Erythematous plaques + adherent scales + dilated pilosebaceous orifices (<u>stippling</u>) + telangiectasia + thin atrophic scar → <u>cicatricial</u> alopecia in sun exposed areas	<u>Herald</u> patch (outer erythematous zone – intermediate scaly one – healing center) parallel to rib / <u>2ry eruption</u> give <u>chrismats</u> tree appearance & jacket with short sleeves
Clinical types	1- <u>Psoriasis vulgaris</u> a. Skin : in extensors – back b. Scalp psoriasis c. Nail psoriasis : bi;ateral pitting hyperkeratotic nail d. Flexural type : scaling is absent 2- <u>Erythrodermic</u> 3- <u>Arthropathic</u> 4- <u>Pustular</u> : sterile pustules	1- <u>Ordinary</u> LP 2- <u>Actinic</u> LP : in sun exposed area in summer 3- <u>Mucosal</u> : reticulate network – ulcerative lesion – precancerous 4- <u>LP of the scalp</u> : cicatricial alopecia		1- <u>Ordinary</u> type 2- <u>Inverted</u> type : occur distal 3- <u>Abortive</u> type : only herald 4- Papular type : more elevated 5- <u>Flexural</u> type
Treatment	1- <u>Local</u> : coal tar – Anthralin 0.5% - corticosteroids – salicylic acid 5% - calcipotriol – PUVA – laser 2- <u>Systemic</u> : for extensive psoriasis : Methotrexate – retinoids – cyclosporine – corticosteroids – PUVA oral	1- <u>Antihistaminics</u> 2- <u>Steroids</u> & salicylic locally 3- <u>Steroids</u> – <u>retinoids</u> and cyclosporine systemically 4- <u>Actinic</u> : sunscreens 0 chloroquine 200mg /day 5- <u>Mucosal</u> : steroids – acitrtin – chloroquine	1- <u>Sun screens</u> 2- Systemic <u>photoprotectives</u> (chloroquine) 3- <u>Corticosteroids</u> (local – systemic – intralesional)	1- PT <u>reassurance</u> 2- Avoid hot baths 3- <u>Calamine</u> lotion 4- Oral <u>antihistaminics</u> , topical corticosteroids and <u>UVB</u>

Allergic Dermatoses

	Eczema	urticaria	Erythema multiforms	Drug eruptions
	May be genetic in types as atopic & allergic contact dermatitis	1- Exogenous : foods as fish-chocolate / drugs as penicillin injected or ingested / pollens 2- Endogenous : infection – parasites – SLE – lymphoma – pregnancy	1- Genetic factors 2- Infections : HSV 3- DRUGS : NSAIDs 4- Autoimmune : SLE 5- Malignancy : lymph	Allergy to the drug
	1- Contact dermatitis : a. 1ry irritant dermatitis : any individual b. Allergic contact dermatitis : type IV in genetic susceptible 2- Discoid eczema : well defined 3- Atopic eczema : genetic with FH a. Infantile : on cheeks & hands b. Childhood : on flexures c. Adult : hyperpigmentation & lichenification 4- Stasis eczema : venous insufficiency → edema oozing vesiculation itching 5- Seborrheic eczema : by malassezia furfur a. Infantile type : scales on scalp & diaper area b. Aadult : from androgens on sebaceous glands	1- Ordinary urticaria 2- Factitious : very mild – follow trauma 3- Cholinergic : itchy sensation after sweating with wheals on scalp –neck upper chest 4- Physical : either solar – pressure – cold –heat 5- Popular : due to insect bite in infants & children / wheal then papule over it	1- EM minor : only limmted to skin – no or mild mucosal involvement – no systemic involvement 2- EM major : extensive mucosal and systemic involvement → death	1- Urticarial & angioedema 2- Erythroderma (exfoliative dermatitis) 3- Photosensitive drug reaction 4- Acneform eruptions (steroids) 5- Fixed drug eruption : with sulfonamides & NSAIDs / fixed to the drug & site / permengnate colored macule vesicles & eruption
	-acute eczema : erythema –swelling – vesicles -chronic eczema : lichenification & excoriations	Sudden appearance of elevated edematous lesion varies in size transient for few hours	Primary lesion : iris (target) lesion erythematous annukar ring with central vesicle / in mucosa : may form painful HGE bullae & erosions	Acute atypical inflammatory eruptions suside after stoppage of drug
	1- Acute : drying antiseptic lotion & corticosteroid cream with hydrous base – systemic antihistaminics & corticosteroids 2- Chronic : local corticosteroids cream 3- Atopic : + topical immunomodulators & UVB 4- Seborrheic : antidandruff shampoo	1- local : cold compresses –calamine lotion – steroids 2- Systemic : oral antihistaminic → parentral AH → oral steroids → parentral steroids → adrenaline SC or IM	3- Local : compresses – calamine lotion – steroids – antiseptics 4- Systemic : antihistaminics – steroids – antibiotics 5- Major needs hospitalization and TTT of complications	

	Vitiligo	ALopecia	Acne
Etiology	Melanocytes are destroyed and disappear from epidermis due to : 1- Autoimmune : antimelanocyte AB precipitated by psycho or mechanical trauma 2- Neurogenic L melanocytotoxic substances from nerve endings 3- Chemical : melanocytotoxic substances from rubber gloves etc 4- UV rays	1- Cicatricial : mechanical trauma – fungal inection DLE – lichen planus 2- Non cicatricial : a. Telogen : postpartum – nutritional deficiency b. Anagen : cytotoxic – retinoids – mercury c. Familial baldness : overactivity 5alfa reductase d. Areata : genetic factors – immunological actors	Block of follicular opening by KCs – dilatation of the lower part – disruption of the epithelium – discharge into the dermis – inflammation especially with propionobacterium acnes lead to papule pastule nodulocystic lesions
Types	1- Focal vitilgo 2- Unilateral vitilgo 3- Generalized vitilgo 4- Universal vitilgo	1- Cicatricial 2- Non cicatricail : telogen effulfium – anagen effluvium – androgenitic alopecia – alopecia areata (patchy – marginaalis – ophiasis – totalis – universalis)	1- Mild ; comedones – no papules 2- Moderate : comedones – paules – pustules 3- Sever : nodules & cysts
DD	DD : tinea versicolor – pityriasis alba- postinflammatory hypopigmentation		
Tratment	1- Phoyototherapy : PUVA 2- Steroids & immunomodulators 3- Surgical : punch grafting & tissue culture 4- camouflage	1- topical ; local irritants – corticosteroids cream – PUVA – minoxidil 2- systemic : antidepressant – corticosteroids	1- topical : erythromycin lotion – retinoids – benzyl peroxide – azelic acid 2- systemic : antibiotics (tetracycline) + retinoids – dapsone & steroids (sever)

The following topics has to be studied from the department book : leprosy & protozoal infections

PREPARED BY
Mahmoud abdel Ghany Behairy